CLAYTOR MEMORIAL CLINIC

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Child/Adolescent Psychiatric Background Information

NAME OF PATIENT: **DOB:** **SEX AT BIRTH: Female / Male**

PSYCHIATRIC HISTORY / INFORMATION

Briefly state the reason you would like your child to see a Psychiatrist/Psychiatric Physician Assoc. When did these symptoms begin?	

Primary Care Physician:	Facility:	Phone Number:
Other/Previous Psychiatrist:	Facility:	Phone Number:
Is your child presently taking prescription medications?		Yes No
If yes, please list them below:		

Current Psychiatric Medications:	Dosage:	How long has the child taken it:	Prescribing Doctor:
Previous Psychiatric Medications:			

Height:	Weight:	When was your child's last medical exam?
Has your child previously been treated by a psychiatrist? Yes No	If so, when?	Briefly describe the reason:
Has your child previously been treated by a Therapist? Yes No	If so, when?	Briefly describe the reason:

Has your child previously been hospitalized for psychiatric reasons? Yes No	If so, when?	Briefly describe the reason:

LEGAL HISTORY

Has your child been involved with the police or juvenile court system? Yes No

If yes, please explain?

Has your child ever had legal charges? Yes No

If yes, please explain?

FAMILY HISTORY / INFORMATION

Father's Name:	Living	Occupation:	Age:
	Deceased	Cause of Death:	Age at time of Death:
Mother's Name:	Living	Occupation:	Age:
	Deceased	Cause of Death:	Age at time of Death:

Are the child's parents divorced or separated? Yes No If yes, what age was the child when they separated/divorced?

Was your child adopted? Yes No

If yes, at what age:

If yes, does the child know? Yes No

List any siblings and their ages:	Name:	Age:	Relationship (biological, half, step, adopted, foster):

List all current members of the child's household:

*Family history **diagnosed by a physician**, Please check all that apply:*

	FATHER	MOTHER	SIBLINGS	OTHER RELATIVES
Alcoholism				
Drug Abuse				
Depression				
Manic Depression				
Anxiety				
Suicide				
ADHD				
Obsessive/Compulsive Disorder				
Eating Disorder				
Other Psychiatric Disorders				
High/Low Blood Pressure				
Seizures				

	FATHER	MOTHER	SIBLINGS	OTHER RELATIVES
Thyroid issues				
Diabetes				
Meningitis				
Heart Murmur				

Does your child have a history of physical, verbal, or sexual abuse? Yes No

If yes, please explain:

DEVELPOMENTAL HISTORY

Were there any difficulties or complications for the mother or child during delivery? (Breathing problems, cord around the neck, problems feeding) Yes No

If yes, please explain:

Did the mother suffer from any illnesses during pregnancy? Yes No

If yes please explain:

Please check any substances that were used during pregnancy:

Tobacco Alcohol Illegal Drugs Prescription Medications Other

If any are checked, please explain:

Was the pregnancy full term? Yes No If no what were # of weeks at delivery?

Mother's age at the time of birth: Father's age at the time of birth:

Type of delivery: Normal Cesarean Breach

At what age did your child:

Walk alone: Use single words: Form sentences: Toilet train:

Has your child ever had an eye and/or hearing exam? Yes No

If yes, when and what were the results?

Has your child experienced a loss of consciousness? Yes No

If yes, please explain:

Has your child experienced a head injury? Yes No

If yes, please explain:

Self help skills: Average Slow Poor
(dressing, brushing, toileting, hygiene)

Has your child ever been separated from either parent? Yes No

If yes, please explain:

If yes, what age?

SCHOOL HISTORY

School Currently Attending: Grade:

Previous Schools Attended: Grades:

Grades:

School Attendance Record: Excellent Good Poor

Has your child had any problems academically? Yes No

If yes, please explain:

Has your child repeated or skipped any grades? Yes No

If yes, please explain:

Has your child experienced any social problems at school? Yes No

If yes, please explain:

Has your child been in detention or suspended? Yes No

If yes, please explain:

Has your child been expelled? Yes No

If yes, please explain:

Has your child experienced any traumatic experiences related to school? Yes No

If yes, please explain:

Has your child had psychological testing? Yes No

If yes, please explain:

Has your child ever had special education services or known learning disabilities? Yes No

If yes, please explain:

Does your child currently have an IEP? Yes No

If yes, please explain:

What does your child do best in school?

SUBSTANCE ABUSE HISTORY

SUBSTANCE	History of use?		Age of first use:	Date of last use:	Use within the past year?	
Alcohol	Yes	No			Yes	No
Barbiturates	Yes	No			Yes	No
Xanax, Valium, Librium	Yes	No			Yes	No
Cocaine, Crack	Yes	No			Yes	No
Heroin, Opiates	Yes	No			Yes	No
Marijuana	Yes	No			Yes	No
PCP, LSD, Mescaline	Yes	No			Yes	No
Inhalants	Yes	No			Yes	No
Caffeine	Yes	No			Yes	No
Nicotine	Yes	No			Yes	No
Amphetamines, Speed, Uppers, Crystal Meth	Yes	No			Yes	No
Designer Drugs, Ecstacy	Yes	No			Yes	No
Over-the-counter medications/supplements	Yes	No			Yes	No

Has your child ever received substance abuse treatment? Yes No

MEDICAL HISTORY

Has your child ever had Blackouts DUI Tremors Hallucinations

Please circle all that apply to your child and list any additional medical history:
Mumps Measles Chicken Pox Seizures Asthma Heart Murmur Thyroid
High Blood Pressure Bowel or Bladder issues Diabetes Surgery Flu
Other_____

ALLERGIES TO MEDICATIONS:

Is there anything you would like to tell us about your child?

REPORT OF CURRENT AND PAST SYMPTOMS

Please check any problems that your child either has had in the past or is currently having.

Current	Past		Current	Past	
		Obsess about checking, counting/ or washing hands			Hear voices
		Feel people are after you, against you, following you			Unusual thinking
		Odd speech/thinking			Not interested in making friends
		Fear of becoming fat			Engage in self-induced vomiting
		Gorging on food			Excessive dieting/exercise
		Use laxatives			Eat things that are not food
		Shy			Expect failure
		Selfish			Lazy
		Avoid Adults			Easy Going
		Friendly			Enthusiastic
		Slow moving			Easily embarrassed
		Few close friends			Lack of responsiveness to others

		Messy			Careless, reckless
		Learning difficulties			Difficulty paying attention

Current	Past		Current	Past	
		Disorganized			Fidgety, restless, overactive
		Talking/acting without thinking			Short attention span
		Frequent daydreams			Self-mutilation
		Bored easily			Vandalism
		Fire-setting			Nightmares
		Afraid to leave a loved one			Fear of strangers
		Often sick on school/work days			Refusing to talk
		Defiant of authority			Often disobedient
		Argumentative			Upset of minor changes
		Stubborn			Temper tantrums/ Sudden anger
		Lack of guilt over wrong doing			Bullies others
		Sexually acting out			Lying
		Truancy			Physically aggressive toward others
		Theft			Lack self-confidence
		Problems with long-term memory			Problems with short-term memory

To be signed by person completing form:

Print Name (Full Name) _____ Relationship to Child _____

Signature (Full Name) _____ Date _____